

INSTRUCTIONS The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05202

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Elkwood</u>		STATE <u>Md.</u> COUNTY <u>Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Elkwood</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY OR TOWN <u>Elkwood</u>		CITY OR TOWN <u>Elkwood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5616 Main St.</u>				STREET ADDRESS (If rural give location) <u>5616 Main St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William L. Bauman</u>				<u>5/24/1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/12/1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>B&O Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Elkwood Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Louis Bauman</u>				14. MOTHER'S MAIDEN NAME <u>Frances Marshaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Mr. Harold Bauman 5616 Main St. Elkwood Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>acute coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>42 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>chronic myocarditis</u>						<u>1 1/2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>chronic Capillary Endocarditis</u>						<u>10 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Paradoxic Disease of spine</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1954</u> to <u>May 27, 1956</u> that I last saw the deceased <u>alive on May 27, 1956</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. Bauman</u>		ADDRESS (Street, city, town, state) <u>Elkwood Md.</u>		DATE SIGNED <u>5/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>5/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Elkwood Memorial</u>		LOCATION (City, town, or county) <u>Elkwood Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>E. Bauman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Brown</u>		ADDRESS <u>2000 1st St. Elkwood Md.</u>	
DATE <u>5/29/56</u>							

VS A13C 1-55 10M

DEATH CERTIFICATE

BUREAU V. J.

MAY 31 1956

RECEIVED

5207

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <u>Howard Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edlicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto md</u> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>41144 Church Job</u>		d. STREET ADDRESS <u>115 S. Collins Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRI F. BRETT SCHNEIDER</u>		4. DATE OF DEATH Month Day Year <u>5/21/56</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/93</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick Brettschneider</u>		14. MOTHER'S MAIDEN NAME <u>Avoca, Pa.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>211-10-2644</u>	
17. INFORMANT <u>Storiz Albert</u> Address <u>712 McAlpine St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY INSUFFICIENCY</u> (c) <u>HYPERTENSIVE CDD</u> INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1956</u> , to <u>May 19, 1956</u> , that I last saw the deceased alive on <u>May 21, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Thatcher</u> M.D.		ADDRESS (Street, city or town, state) <u>4404 LIBERTY Hgts May 22, 1956</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH C. THATCHER</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Pratt & Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>May 28-56</u> 24b. REGISTRAR'S SIGNATURE <u>John B. Longhane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar		13. Date of registration		14. Registrar's office	

5208

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH o. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY HOWARD STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SIMPSONVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SIMPSONVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARSHALL BROOKS				4. DATE OF DEATH MAY 22 1956			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879 77	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABOR		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) HIGHLAND Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM BROOKS				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address CALEB BROOKS, SIMPSONVILLE Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO WITH HYPERTENSION (c) 20 YEARS						INTERVAL BETWEEN ONSET AND DEATH 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 30, 1956 , to MAY 22, 1956 , that I last saw the deceased alive on MAY 20, 1956 , and that death occurred at 6:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles S. Whitaker M.D.				ADDRESS (Street, city or town, state) CLARKSVILLE, MD. DATE SIGNED 5/24/56			
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-26-56		22c. NAME OF CEMETERY OR CREMATORY LOCUST CHAPEL		22d. LOCATION (City, town, or county) (State) SIMPSONVILLE Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. H. GIBBOTHAM, ELICOTT CITY Md				24a. REC'D BY REGISTRAR DATE 5/24/56		24b. REGISTRAR'S SIGNATURE Marie A. Whitaker	

MEDICAL CERTIFICATION

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NO STATE DEPARTMENT OF HEALTH - BALTICORE 13

1009

BUREAU V. E.

MAY 29 1956

RECEIVED

5209

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Orchard				d. STREET ADDRESS Pine Orchard			
3. NAME OF DECEASED (Type or print) MARTHA ANN CROSS				4. DATE OF DEATH Month May Day 21 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1876		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Ivory, Md		11. BIRTHPLACE (State or foreign country) Ivory, Md	
13. FATHER'S NAME Basil T. Grimes				14. MOTHER'S MAIDEN NAME Charity Olivia Selby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charity Cross, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 1 , 19 50 , to May 21 , 19 56 , that I last saw the deceased alive on May 21 , 19 56 , and that death occurred at 12:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Leon A. Kochman				ADDRESS (Street, city or town, state) Ellicott City, Md			
PHYSICIAN'S NAME (Type) Dr. Leon A. Kochman				DATE SIGNED 5/21/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-24-56		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR May 23, 56		24b. REGISTRAR'S SIGNATURE John B. Loughran, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 25 1956

5210

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 03X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highland Manor Nursing Home</u>				d. STREET ADDRESS <u>531 Stonington Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>MAMIE</u> Middle <u>MYRLE</u> Last <u>DEVILBISS</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 12, 1876</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd-Ribbon Buyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>John Smith Devilbiss</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Stemm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-09-3214</u>		17. INFORMANT <u>Miss Felicia Finch - 1700 Appleton St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old Cerebral Vasc. Accident, gradually Arteriosclerotic</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 1956</u> , to <u>May 24, 1956</u> , that I last saw the deceased alive on <u>5/19</u> , 19 <u>56</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Balt. Nat. Pike</u> DATE SIGNED <u>5/25/56</u>							
ACTUAL SIGNATURE <u>Wm J. Lickner</u> M.D. <u>5226</u>		Baltimore 29 Md.					
PHYSICIAN'S NAME (Type) <u>Wm J. Lickner M.D.</u>		Baltimore 29 Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickner & Sons - Balt. 17 Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Loughran</u>	

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 8

MAY 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05207
5211 CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Rural)</u>	LENGTH OF STAY (in this place) <u>24 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 351A RFD 4</u>		STREET ADDRESS (If rural give location) <u>Box 351A RFD 4</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>William Thomas Dixon</u>		<u>May 4 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Feb 13-1873</u>
9. AGE last birthday <u>83</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Howard Co Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Policeman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Annie Shipley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>Wm T. Dixon</u>	
17. INFORMANT & ADDRESS: <u>Wm T. Dixon</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>420.1</u>		<u>Acute Coronary occlusion</u>	
ANTECEDENT CAUSE (S) <u>Due to</u>		<u>Chronic Myocarditis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Due to</u>		<u>Decompensation</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>		<u>5 yrs</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 2, 1936</u> to <u>May 4, 1956</u> , that I last saw the deceased alive on <u>May 4, 1956</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>B. B. Brumbaugh</u>		DATE SIGNED <u>5/4/56</u>	
M. D. <u>5609 main st. Elkridge 27 Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/8/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Powdon Park</u>		LOCATION (City, town, or county) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR <u>Harold Cole</u>	
REGISTRAR'S SIGNATURE		ADDRESS <u>1913 W. Balto. St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF PUBLIC AFFAIRS

7-11-68

11

1

11/11/68

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05208

5212 **CERTIFICATE OF DEATH**

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Howard</u>		STATE <u>Maryland</u>		COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Daniels</u>		LENGTH OF STAY (in this place) <u>43 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Daniels</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Railroad Avenue</u>				STREET ADDRESS (If rural give location) <u>Railroad Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Ary</u> (First) <u>Rebecca</u> (Middle) <u>Gamber</u> (Last)				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>21</u> (Year) <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/23/1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George C Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Ary R Tillman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>C Dewey Gamber Daniels Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Congestive pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/21/1956</u> , to <u>5/21/1956</u> , that I last saw the deceased alive on <u>5/21/1956</u> , and that death occurred at <u>5/21/1956</u> M., from the causes and on the date stated above. SIGNATURE <u>Wm. E. Martin</u> M.D. <u>Randalstown</u> DATE SIGNED <u>5/22/56</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		LOCATION (City, town, or county) <u>Reisterstown Md</u>	
24. REC'D BY REGISTRAR <u>5-22-56</u>		REGISTRAR'S SIGNATURE <u>Mary B. Shime</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Berryman Jones</u>		ADDRESS <u>Reisterstown Md</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	

BUREAU V. B.

MAY 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5213

CERTIFICATE OF DEATH

05209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First E. Middle PEARL Last MERCIER		4. DATE OF DEATH Month May Day 16 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1872
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher Retired		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas B. Mercier		14. MOTHER'S MAIDEN NAME Ellen Amelia Woods	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. June Ridgely, Lisbon, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Not Known (Probably several years) Not Known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 1956, to May , 1956, that I last saw the deceased alive on May 14 , 1956, and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mount Airy, Md DATE SIGNED May 16, 1956			
ACTUAL SIGNATURE W.B. Culwell		M.D. Mount Airy, Md	
PHYSICIAN'S NAME (Type) W.B. Culwell			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-19-1956	
22c. NAME OF CEMETERY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE L.M. Waetz		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR MAY 18 1956		24b. REGISTRAR'S SIGNATURE A.H. Sedwick	

CERTIFICATE OF DEATH

5013

DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. S.

MAY 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05210

5214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EL LICOTT CITY			c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Highland Manor Nursing Home				d. STREET ADDRESS 227 Spring Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS Middle PEZZOLI Last				4. DATE OF DEATH Month 5 Day 10 Year 1956			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Majestic		10b. KIND OF BUSINESS OR INDUSTRY Pickles Factory		11. BIRTHPLACE (State or foreign country) Ripatranzone Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Giuseppe Pezzoli				14. MOTHER'S MAIDEN NAME Teresa Telamonti			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-07-5607		17. INFORMANT Address Margaret Pezzoli 227 Spring Ct.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Arterio sclerotic Cardio Vascular Disease 5 Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>George E. Burgtorf</i> M.D. EXAMINER'S NAME (Type) GEORGE E. BURGTORF				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-10-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 12 1956		22c. NAME OF CEMETERY OR CREMATORY St Stanislaus		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Frank Della Voce</i> 322 S. High St.				24a. REC'D BY REGISTRAR DATE 5/11/56		24b. REGISTRAR'S SIGNATURE <i>J. Langerman</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BARNHART 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED THOMAS		AGE A - 17 - 1800	SEX M	RACE W	RELIGION C
DATE OF DEATH A - 17 - 1800		TIME OF DEATH A - 17 - 1800	PLACE OF DEATH A - 17 - 1800	CITY A - 17 - 1800	COUNTY A - 17 - 1800
CAUSE OF DEATH A - 17 - 1800		MANNER OF DEATH A - 17 - 1800	EDUCATION A - 17 - 1800	PROFESSION A - 17 - 1800	INDUSTRY A - 17 - 1800
DISEASES PRECEDING DEATH A - 17 - 1800		SYMPTOMS A - 17 - 1800	DIAGNOSIS A - 17 - 1800	TREATMENT A - 17 - 1800	PROGNOSIS A - 17 - 1800
SIGNATURE OF EXAMINER A - 17 - 1800		DATE OF EXAMINATION A - 17 - 1800	PLACE OF EXAMINATION A - 17 - 1800	CITY A - 17 - 1800	COUNTY A - 17 - 1800

BUREAU V. E.

MAY 14 1956

RECEIVED

05211

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5215

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY How.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Franciscan Fathers Seminary		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) Rev. Mark Rawinisz O.F.M.Conv..		4. DATE OF DEATH (Month) (Day) (Year) May 3rd 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb. 9, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Franciscan Priest		10b. KIND OF BUSINESS OR INDUSTRY Religious	9. AGE last birthday 46 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John V. Rawinisz		14. MOTHER'S MAIDEN NAME Catherine Rybarczyk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Rev. Flavian Goral O.F.M.Conv.-Ellicott City			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4201
Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Acute Coronary Occlusion*
 (b) *Degenerative C.V. Disease. Marked cardiac hypertrophy. Hypertension.*
 (c) *Coronary sclerosis and insufficiency*

INTERVAL BETWEEN ONSET AND DEATH

years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *January 1949*, to *3 May*, 1956, that I last saw the deceased alive on *3 May*, 1956, and that death occurred at *9:00 A.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Entombment	DATE THEREOF May 7th, 1956	NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	LOCATION (City, town, or county) 1300 Dundalk Ave Balto, Md.
--	--------------------------------------	---	--

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>May 7, 1956</i>	24. FUNERAL DIRECTOR <i>George A. Weber</i>	ADDRESS <i>705 So Ann st</i>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1915

5216

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 144 1 1/2 miles east of Cooksville Mc Kendree Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Rt. 144	
3. NAME OF DECEASED (Type or print) First Middle Last DANNY WAYNE RIDGELY		4. DATE OF DEATH Month Day Year May 16, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1948
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY West Friendship Lieben School	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. A.	
13. FATHER'S NAME William H. Ridgely		14. MOTHER'S MAIDEN NAME Margaret J. Henderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. H. Ridgely - Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of upper four cervical vertebrae 812X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple fractures INTERVAL BETWEEN ONSET AND DEATH Instant			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Pedestrian crossing highway and struck by car		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 3:45 a.m. 5-16 19 56		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Cooksville Howard Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George E. Purgatorf		DATE SIGNED 5-16-56	
EXAMINER'S NAME (Type) George E. Purgatorf M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-19-56	
22c. NAME OF CEMETERY OR CREMATORY Providence		22d. LOCATION (City, town, or county) (State) Shells Howard Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight - Sykesville, Md.		24. REC'D BY REGISTRAR 3/18/56	
25. REGISTRAR'S SIGNATURE W. H. Hedrick			

MEDICAL CERTIFICATION

13

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 22 1956

05213

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5217

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>HOWARD</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>SAVAGE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELKRIDGE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 COMMERCIAL ST.</u>		STREET ADDRESS <u>1946 RAILROAD AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>FRANK</u> (Middle) <u>EDWARD</u> (Last) <u>RYAN JR.</u>	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Unknown 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOILERMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>CUMBERLAND MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>FRANK EDWARD RYAN SR</u>		14. MOTHER'S MAIDEN NAME <u>EDITH OBETZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>705-07-2368</u>	
17. INFORMANT AND ADDRESS <u>MARY CHESGREEN - address #1 - daughter</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4221 Immediate cause	(a) <u>CONGESTIVE HEART FAILURE</u>	<u>9 yr.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>CHRONIC MYO CARDITIS</u>	<u>years</u>
	(c) <u>ARTERIO SCLEROSIS</u>	<u>years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 10, 1956, to MAY 17, 1956, that I last saw the deceased alive on MAY 17, 1956, and that death occurred at 9:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

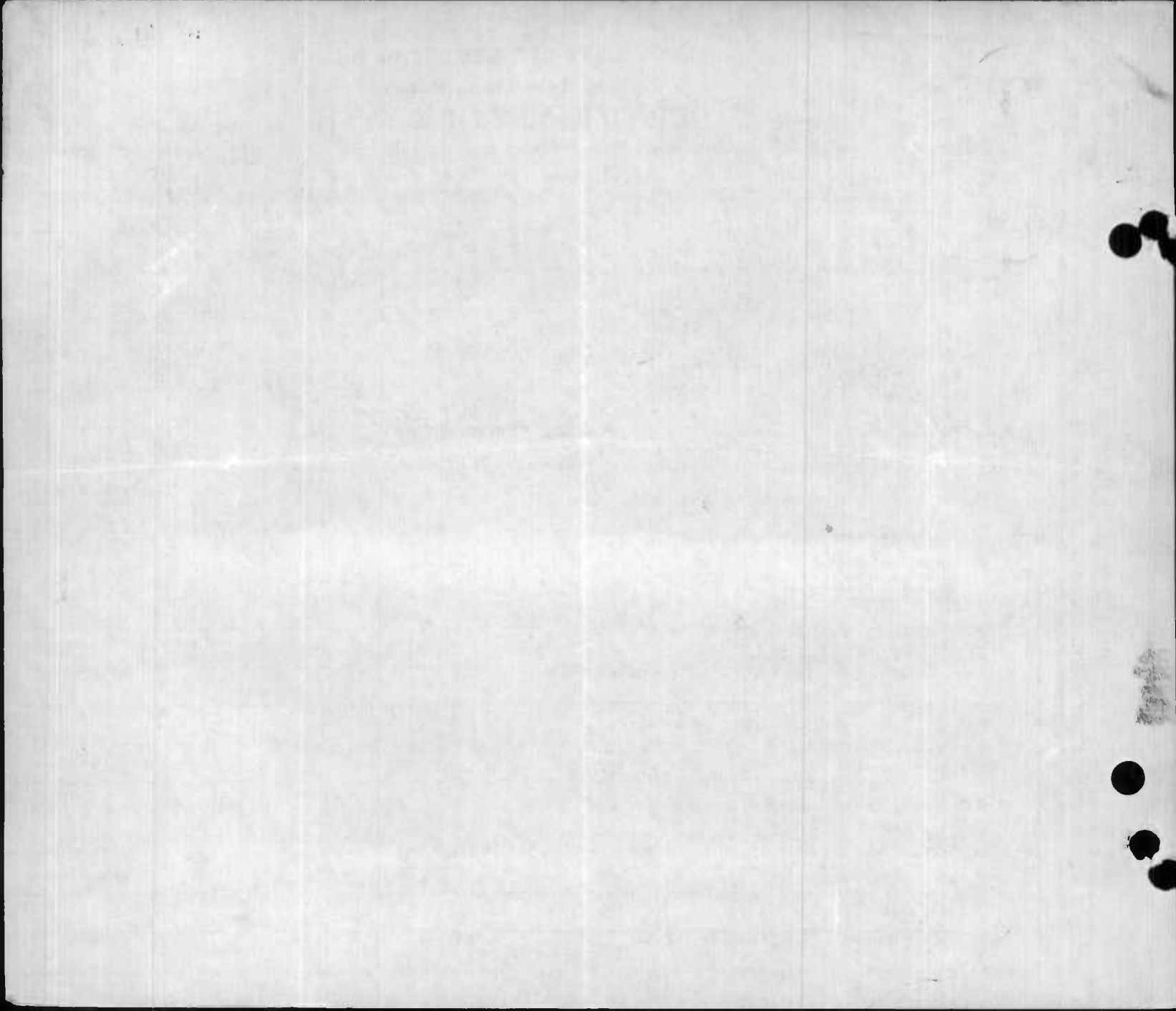
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>5/21/56</u>	NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	LOCATION (City, town, or county) <u>3801 Frederick Ave.</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>May 17, 1956</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>John J. Cowan & Son</u>		ADDRESS <u>25 Collins St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



4957

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Howard County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William David Middle Zimmerman Last		4. DATE OF DEATH Month May Day 10 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1875
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Bank	
11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George H. Zimmerman		14. MOTHER'S MAIDEN NAME Florence Frazier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-14-5357	
17. INFORMANT W. Douglas Zimmerman-30 E. 3rd. St.-Frederick-		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 days years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr 24 , 1956 , to May 10 , 1956 , that I last saw the deceased alive on May 10 , 1956 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving J. Taylor M.D. Taylor Manor Hospital May 10, 1956 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D. Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 13-1956	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Clune Son		24a. REC'D BY REGISTRAR DATE 12 May 1956	
ADDRESS Frederick Md		24b. REGISTRAR'S SIGNATURE Shirley B. Hark J. C. Loughran	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. S.

MAY 15 1956

RECEIVED

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